MISSISSIPPI LEGISLATURE REGULAR SESSION 2000

By: McBride, Rushing

To: Public Health and Welfare; Appropriations

HOUSE BILL NO. 734

1 AN ACT TO AMEND SECTION 43-13-115, MISSISSIPPI CODE OF 1972,
2 TO PROVIDE THAT PERSONS WHO ARE ELIGIBLE FOR MEDICARE AND WHOSE
3 INCOME DOES NOT EXCEED 250% OF THE POVERTY LEVEL SHALL BE ELIGIBLE
4 FOR MEDICAID; TO PROVIDE THAT THOSE PERSONS SHALL BE ELIGIBLE ONLY
5 FOR PRESCRIPTION DRUGS COVERED UNDER MEDICAID; TO DIRECT THE
6 DIVISION OF MEDICAID TO APPLY FOR A FEDERAL WAIVER TO ALLOW FOR
7 THE IMPLEMENTATION OF THE PRECEDING PROVISIONS; TO AMEND SECTION
8 43-13-117, MISSISSIPPI CODE OF 1972, TO PROVIDE THAT THERE WILL BE
9 NO LIMIT ON THE NUMBER OF PRESCRIPTIONS PER MONTH FOR MEDICAID
10 RECIPIENTS WHO ARE ELIGIBLE UNDER THE PRECEDING PROVISION; TO
11 PROVIDE THAT PRESCRIPTIONS FOR THOSE MEDICAID RECIPIENTS SHALL BE
12 FUNDED FROM STATE FUNDS APPROPRIATED TO THE DIVISION OF MEDICAID
13 FROM THE HEALTH CARE EXPENDABLE FUND AND MATCHING FEDERAL FUNDS;
14 AND FOR RELATED PURPOSES.

15 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MISSISSIPPI:

16 SECTION 1. Section 43-13-115, Mississippi Code of 1972, is
17 amended as follows:

18 43-13-115. Recipients of medical assistance shall be the
19 following persons only:

20 (1) Who are qualified for public assistance grants under
21 provisions of Title IV-A and E of the federal Social Security Act,
22 as amended, including those statutorily deemed to be IV-A as
23 determined by the State Department of Human Services and certified
24 to the Division of Medicaid, but not optional groups unless
25 otherwise specifically covered in this section. For the purposes
26 of this paragraph (1) and paragraphs (3), (4), (8), (14), (17) and
27 (18) of this section, any reference to Title IV-A or to Part A of
28 Title IV of the federal Social Security Act, as amended, or the
29 state plan under Title IV-A or Part A of Title IV, shall be
30 considered as a reference to Title IV-A of the federal Social
31 Security Act, as amended, and the state plan under Title IV-A,
32 including the income and resource standards and methodologies

33 under Title IV-A and the state plan, as they existed on July 16,
34 1996.
35 (2) Those qualified for Supplemental Security Income (SSI)
36 benefits under Title XVI of the federal Social Security Act, as
37 amended. The eligibility of individuals covered in this paragraph
38 shall be determined by the Social Security Administration and
39 certified to the Division of Medicaid.
40 (3) Qualified pregnant women as defined in Section 1905(n)
41 of the federal Social Security Act, as amended, and as determined
42 to be eligible by the State Department of Human Services and
43 certified to the Division of Medicaid, who:
44 (a) Would be eligible for assistance under Part A of
45 Title IV (or would be eligible for such assistance if coverage
46 under the state plan under Part A of Title IV included assistance
47 pursuant to Section 407 of Title IV-A of the federal Social
48 Security Act, as amended) if her child had been born and was
49 living with her in the month such assistance would be paid, and
50 such pregnancy has been medically verified; or
51 (b) Is a member of a family which would be eligible
52 for assistance under the state plan under Part A of Title IV of
53 the federal Social Security Act, as amended, pursuant to Section
54 407 if the plan required the payment of assistance pursuant to
55 such section.
56 (4) Qualified children who are under five (5) years of age,
57 who were born after September 30, 1983, and who meet the income
58 and resource requirements of the state plan under Part A of Title
59 IV of the federal Social Security Act, as amended. The
60 eligibility of individuals covered in this paragraph shall be
61 determined by the State Department of Human Services and certified
62 to the Division of Medicaid.
63 (5) A child born on or after October 1, 1984, to a woman
64 eligible for and receiving medical assistance under the state plan
65 on the date of the child's birth shall be deemed to have applied
66 for medical assistance and to have been found eligible for such
67 assistance under such plan on the date of such birth and will
68 remain eligible for such assistance for a period of one (1) year
69 so long as the child is a member of the woman's household and the

70 woman remains eligible for such assistance or would be eligible
71 for assistance if pregnant. The eligibility of individuals
72 covered in this paragraph shall be determined by the State
73 Department of Human Services and certified to the Division of
74 Medicaid.
75 (6) Children certified by the State Department of Human
76 Services to the Division of Medicaid of whom the state and county
77 human services agency has custody and financial responsibility,
78 and children who are in adoptions subsidized in full or part by
79 the Department of Human Services, who are approvable under Title
80 XIX of the Medicaid program.
81 (7) (a) Persons certified by the Division of Medicaid who
82 are patients in a medical facility (nursing home, hospital,
83 tuberculosis sanatorium or institution for treatment of mental
84 diseases), and who, except for the fact that they are patients in
85 such medical facility, would qualify for grants under Title IV,
86 supplementary security income benefits under Title XVI or state
87 supplements, and those aged, blind and disabled persons who would
88 not be eligible for supplemental security income benefits under
89 Title XVI or state supplements if they were not institutionalized
90 in a medical facility but whose income is below the maximum
91 standard set by the Division of Medicaid, which standard shall not
92 exceed that prescribed by federal regulation;
93 (b) Individuals who have elected to receive hospice
94 care benefits and who are eligible using the same criteria and
95 special income limits as those in institutions as described in
96 subparagraph (a) of this paragraph (7).
97 (8) Children under eighteen (18) years of age and pregnant
98 women (including those in intact families) who meet the financial
99 standards of the state plan approved under Title IV-A of the
100 federal Social Security Act, as amended. The eligibility of
101 children covered under this paragraph shall be determined by the
102 State Department of Human Services and certified to the Division

103 of Medicaid.

104 (9) Individuals who are:

105 (a) Children born after September 30, 1983, who have
106 not attained the age of nineteen (19), with family income that
107 does not exceed one hundred percent (100%) of the nonfarm official
108 poverty line;

109 (b) Pregnant women, infants and children who have not
110 attained the age of six (6), with family income that does not
111 exceed one hundred thirty-three percent (133%) of the federal
112 poverty level; and

113 (c) Pregnant women and infants who have not attained
114 the age of one (1), with family income that does not exceed one
115 hundred eighty-five percent (185%) of the federal poverty level.

116 The eligibility of individuals covered in (a), (b) and (c) of
117 this paragraph shall be determined by the Department of Human
118 Services.

119 (10) Certain disabled children age eighteen (18) or under
120 who are living at home, who would be eligible, if in a medical
121 institution, for SSI or a state supplemental payment under Title
122 XVI of the federal Social Security Act, as amended, and therefore
123 for Medicaid under the plan, and for whom the state has made a
124 determination as required under Section 1902(e)(3)(b) of the
125 federal Social Security Act, as amended. The eligibility of
126 individuals under this paragraph shall be determined by the
127 Division of Medicaid.

128 (11) Individuals who are sixty-five (65) years of age or
129 older or are disabled as determined under Section 1614(a)(3) of
130 the federal Social Security Act, as amended, and who meet the
131 following criteria:

132 (a) Whose income does not exceed one hundred percent
133 (100%) of the nonfarm official poverty line as defined by the
134 Office of Management and Budget and revised annually.

135 (b) Whose resources do not exceed those allowed under

136 the Supplemental Security Income (SSI) program.

137 The eligibility of individuals covered under this paragraph
138 shall be determined by the Division of Medicaid, and such
139 individuals determined eligible shall receive the same Medicaid
140 services as other categorical eligible individuals.

141 (12) Individuals who are qualified Medicare beneficiaries
142 (QMB) entitled to Part A Medicare as defined under Section 301,
143 Public Law 100-360, known as the Medicare Catastrophic Coverage
144 Act of 1988, and who meet the following criteria:

145 (a) Whose income does not exceed one hundred percent
146 (100%) of the nonfarm official poverty line as defined by the
147 Office of Management and Budget and revised annually.

148 (b) Whose resources do not exceed two hundred percent
149 (200%) of the amount allowed under the Supplemental Security
150 Income (SSI) program as more fully prescribed under Section 301,
151 Public Law 100-360.

152 The eligibility of individuals covered under this paragraph
153 shall be determined by the Division of Medicaid, and such
154 individuals determined eligible shall receive Medicare
155 cost-sharing expenses only as more fully defined by the Medicare
156 Catastrophic Coverage Act of 1988.

157 (13) Individuals who are entitled to Medicare Part B as
158 defined in Section 4501 of the Omnibus Budget Reconciliation Act
159 of 1990, and who meet the following criteria:

160 (a) Whose income does not exceed the percentage of the
161 nonfarm official poverty line as defined by the Office of
162 Management and Budget and revised annually which, on or after:

163 (i) January 1, 1993, is one hundred ten percent
164 (110%); and

165 (ii) January 1, 1995, is one hundred twenty
166 percent (120%).

167 (b) Whose resources do not exceed two hundred percent
168 (200%) of the amount allowed under the Supplemental Security

169 Income (SSI) program as described in Section 301 of the Medicare
170 Catastrophic Coverage Act of 1988.
171 The eligibility of individuals covered under this paragraph
172 shall be determined by the Division of Medicaid, and such
173 individuals determined eligible shall receive Medicare cost
174 sharing.
175 (14) Individuals in families who would be eligible for the
176 unemployed parent program under Section 407 of Title IV-A of the
177 federal Social Security Act, as amended, but do not receive
178 payments pursuant to that section. The eligibility of individuals
179 covered in this paragraph shall be determined by the Department of
180 Human Services.
181 (15) Disabled workers who are eligible to enroll in Part A
182 Medicare as required by Public Law 101-239, known as the Omnibus
183 Budget Reconciliation Act of 1989, and whose income does not
184 exceed two hundred percent (200%) of the federal poverty level as
185 determined in accordance with the Supplemental Security Income
186 (SSI) program. The eligibility of individuals covered under this
187 paragraph shall be determined by the Division of Medicaid and such
188 individuals shall be entitled to buy-in coverage of Medicare Part
189 A premiums only under the provisions of this paragraph (15).
190 (16) In accordance with the terms and conditions of approved
191 Title XIX waiver from the United States Department of Health and
192 Human Services, persons provided home- and community-based
193 services who are physically disabled and certified by the Division
194 of Medicaid as eligible due to applying the income and deeming
195 requirements as if they were institutionalized.
196 (17) In accordance with the terms of the federal Personal
197 Responsibility and Work Opportunity Reconciliation Act of 1996
198 (Public Law 104-193), persons who become ineligible for assistance
199 under Title IV-A of the federal Social Security Act, as amended,
200 because of increased income from or hours of employment of the
201 caretaker relative or because of the expiration of the applicable

202 earned income disregards, who were eligible for Medicaid for at
203 least three (3) of the six (6) months preceding the month in which
204 such ineligibility begins, shall be eligible for Medicaid
205 assistance for up to twenty-four (24) months; however, Medicaid
206 assistance for more than twelve (12) months may be provided only
207 if a federal waiver is obtained to provide such assistance for
208 more than twelve (12) months and federal and state funds are
209 available to provide such assistance.
210 (18) Persons who become ineligible for assistance under
211 Title IV-A of the federal Social Security Act, as amended, as a
212 result, in whole or in part, of the collection or increased
213 collection of child or spousal support under Title IV-D of the
214 federal Social Security Act, as amended, who were eligible for
215 Medicaid for at least three (3) of the six (6) months immediately
216 preceding the month in which such ineligibility begins, shall be
217 eligible for Medicaid for an additional four (4) months beginning
218 with the month in which such ineligibility begins.
219 (19) Disabled workers, whose incomes are above the Medicaid
220 eligibility limits, but below two hundred fifty percent (250%) of
221 the federal poverty level, shall be allowed to purchase Medicaid
222 coverage on a sliding fee scale developed by the Division of
223 Medicaid.
224 (20) Individuals who are eligible for Medicare, who
225 otherwise would not be eligible for Medicaid because of their
226 income or resources and whose income does not exceed two hundred
227 fifty percent (250%) of the federal poverty level. The
228 eligibility of individuals covered under this paragraph (20) shall
229 be determined by the Division of Medicaid. Individuals who are
230 determined eligible shall only receive prescription drugs covered
231 under Section 43-13-117(9) and not any other services covered
232 under Section 43-13-117. However, any individual eligible under
233 this paragraph (20) who is also eligible under any other paragraph
234 of this section shall receive the benefits to which he or she is

235 entitled under the other paragraph, in addition to prescription
236 drugs covered under Section 43-13-117(9).
237 The Division of Medicaid shall apply to the United States
238 Secretary of Health and Human Services for a federal waiver of the
239 applicable provisions of Title XIX of the federal Social Security
240 Act, as amended, and any other applicable provisions of federal
241 law as necessary to allow for the implementation of this paragraph
242 (20). The provisions of this paragraph (20) shall be implemented
243 from and after the date that the Division of Medicaid receives the
244 federal waiver.
245 SECTION 2. Section 43-13-117, Mississippi Code of 1972, is
246 amended as follows:
247 43-13-117. Medical assistance as authorized by this article
248 shall include payment of part or all of the costs, at the
249 discretion of the division or its successor, with approval of the
250 Governor, of the following types of care and services rendered to
251 eligible applicants who shall have been determined to be eligible
252 for such care and services, within the limits of state
253 appropriations and federal matching funds:
254 (1) Inpatient hospital services.
255 (a) The division shall allow thirty (30) days of
256 inpatient hospital care annually for all Medicaid recipients;
257 however, before any recipient will be allowed more than fifteen
258 (15) days of inpatient hospital care in any one (1) year, he must
259 obtain prior approval therefor from the division. The division
260 shall be authorized to allow unlimited days in disproportionate
261 hospitals as defined by the division for eligible infants under
262 the age of six (6) years.
263 (b) From and after July 1, 1994, the Executive Director
264 of the Division of Medicaid shall amend the Mississippi Title XIX
265 Inpatient Hospital Reimbursement Plan to remove the occupancy rate
266 penalty from the calculation of the Medicaid Capital Cost
267 Component utilized to determine total hospital costs allocated to

268 the Medicaid Program.

269 (2) Outpatient hospital services. Provided that where the
270 same services are reimbursed as clinic services, the division may
271 revise the rate or methodology of outpatient reimbursement to
272 maintain consistency, efficiency, economy and quality of care.

273 (3) Laboratory and x-ray services.

274 (4) Nursing facility services.

275 (a) The division shall make full payment to nursing
276 facilities for each day, not exceeding fifty-two (52) days per
277 year, that a patient is absent from the facility on home leave.
278 Payment may be made for the following home leave days in addition
279 to the 52-day limitation: Christmas, the day before Christmas,
280 the day after Christmas, Thanksgiving, the day before Thanksgiving
281 and the day after Thanksgiving. However, before payment may be
282 made for more than eighteen (18) home leave days in a year for a
283 patient, the patient must have written authorization from a
284 physician stating that the patient is physically and mentally able
285 to be away from the facility on home leave. Such authorization
286 must be filed with the division before it will be effective and
287 the authorization shall be effective for three (3) months from the
288 date it is received by the division, unless it is revoked earlier
289 by the physician because of a change in the condition of the
290 patient.

291 (b) From and after July 1, 1993, the division shall
292 implement the integrated case-mix payment and quality monitoring
293 system developed pursuant to Section 43-13-122, which includes the
294 fair rental system for property costs and in which recapture of
295 depreciation is eliminated. The division may revise the
296 reimbursement methodology for the case-mix payment system by
297 reducing payment for hospital leave and therapeutic home leave
298 days to the lowest case-mix category for nursing facilities,
299 modifying the current method of scoring residents so that only
300 services provided at the nursing facility are considered in

301 calculating a facility's per diem, and the division may limit
302 administrative and operating costs, but in no case shall these
303 costs be less than one hundred nine percent (109%) of the median
304 administrative and operating costs for each class of facility, not
305 to exceed the median used to calculate the nursing facility
306 reimbursement for fiscal year 1996, to be applied uniformly to all
307 long-term care facilities.

308 (c) From and after July 1, 1997, all state-owned
309 nursing facilities shall be reimbursed on a full reasonable costs
310 basis. From and after July 1, 1997, payments by the division to
311 nursing facilities for return on equity capital shall be made at
312 the rate paid under Medicare (Title XVIII of the Social Security
313 Act), but shall be no less than seven and one-half percent (7.5%)
314 nor greater than ten percent (10%).

315 (d) A Review Board for nursing facilities is
316 established to conduct reviews of the Division of Medicaid's
317 decision in the areas set forth below:

318 (i) Review shall be heard in the following areas:

319 (A) Matters relating to cost reports
320 including, but not limited to, allowable costs and cost
321 adjustments resulting from desk reviews and audits.

322 (B) Matters relating to the Minimum Data Set
323 Plus (MDS +) or successor assessment formats including but not
324 limited to audits, classifications and submissions.

325 (ii) The Review Board shall be composed of six (6)
326 members, three (3) having expertise in one (1) of the two (2)
327 areas set forth above and three (3) having expertise in the other
328 area set forth above. Each panel of three (3) shall only review
329 appeals arising in its area of expertise. The members shall be
330 appointed as follows:

331 (A) In each of the areas of expertise defined
332 under subparagraphs (i)(A) and (i)(B), the Executive Director of
333 the Division of Medicaid shall appoint one (1) person chosen from

334 the private sector nursing home industry in the state, which may
335 include independent accountants and consultants serving the
336 industry;
337 (B) In each of the areas of expertise defined
338 under subparagraphs (i)(A) and (i)(B), the Executive Director of
339 the Division of Medicaid shall appoint one (1) person who is
340 employed by the state who does not participate directly in desk
341 reviews or audits of nursing facilities in the two (2) areas of
342 review;
343 (C) The two (2) members appointed by the
344 Executive Director of the Division of Medicaid in each area of
345 expertise shall appoint a third member in the same area of
346 expertise.
347 In the event of a conflict of interest on the part of any
348 Review Board members, the Executive Director of the Division of
349 Medicaid or the other two (2) panel members, as applicable, shall
350 appoint a substitute member for conducting a specific review.
351 (iii) The Review Board panels shall have the power
352 to preserve and enforce order during hearings; to issue subpoenas;
353 to administer oaths; to compel attendance and testimony of
354 witnesses; or to compel the production of books, papers, documents
355 and other evidence; or the taking of depositions before any
356 designated individual competent to administer oaths; to examine
357 witnesses; and to do all things conformable to law that may be
358 necessary to enable it effectively to discharge its duties. The
359 Review Board panels may appoint such person or persons as they
360 shall deem proper to execute and return process in connection
361 therewith.
362 (iv) The Review Board shall promulgate, publish
363 and disseminate to nursing facility providers rules of procedure
364 for the efficient conduct of proceedings, subject to the approval
365 of the Executive Director of the Division of Medicaid and in
366 accordance with federal and state administrative hearing laws and

367 regulations.

368 (v) Proceedings of the Review Board shall be of
369 record.

370 (vi) Appeals to the Review Board shall be in
371 writing and shall set out the issues, a statement of alleged facts
372 and reasons supporting the provider's position. Relevant
373 documents may also be attached. The appeal shall be filed within
374 thirty (30) days from the date the provider is notified of the
375 action being appealed or, if informal review procedures are taken,
376 as provided by administrative regulations of the Division of
377 Medicaid, within thirty (30) days after a decision has been
378 rendered through informal hearing procedures.

379 (vii) The provider shall be notified of the
380 hearing date by certified mail within thirty (30) days from the
381 date the Division of Medicaid receives the request for appeal.
382 Notification of the hearing date shall in no event be less than
383 thirty (30) days before the scheduled hearing date. The appeal
384 may be heard on shorter notice by written agreement between the
385 provider and the Division of Medicaid.

386 (viii) Within thirty (30) days from the date of
387 the hearing, the Review Board panel shall render a written
388 recommendation to the Executive Director of the Division of
389 Medicaid setting forth the issues, findings of fact and applicable
390 law, regulations or provisions.

391 (ix) The Executive Director of the Division of
392 Medicaid shall, upon review of the recommendation, the proceedings
393 and the record, prepare a written decision which shall be mailed
394 to the nursing facility provider no later than twenty (20) days
395 after the submission of the recommendation by the panel. The
396 decision of the executive director is final, subject only to
397 judicial review.

398 (x) Appeals from a final decision shall be made to
399 the Chancery Court of Hinds County. The appeal shall be filed

400 with the court within thirty (30) days from the date the decision
401 of the Executive Director of the Division of Medicaid becomes
402 final.
403 (xi) The action of the Division of Medicaid under
404 review shall be stayed until all administrative proceedings have
405 been exhausted.
406 (xii) Appeals by nursing facility providers
407 involving any issues other than those two (2) specified in
408 subparagraphs (i)(A) and (ii)(B) shall be taken in accordance with
409 the administrative hearing procedures established by the Division
410 of Medicaid.
411 (e) When a facility of a category that does not require
412 a certificate of need for construction and that could not be
413 eligible for Medicaid reimbursement is constructed to nursing
414 facility specifications for licensure and certification, and the
415 facility is subsequently converted to a nursing facility pursuant
416 to a certificate of need that authorizes conversion only and the
417 applicant for the certificate of need was assessed an application
418 review fee based on capital expenditures incurred in constructing
419 the facility, the division shall allow reimbursement for capital
420 expenditures necessary for construction of the facility that were
421 incurred within the twenty-four (24) consecutive calendar months
422 immediately preceding the date that the certificate of need
423 authorizing such conversion was issued, to the same extent that
424 reimbursement would be allowed for construction of a new nursing
425 facility pursuant to a certificate of need that authorizes such
426 construction. The reimbursement authorized in this subparagraph
427 (e) may be made only to facilities the construction of which was
428 completed after June 30, 1989. Before the division shall be
429 authorized to make the reimbursement authorized in this
430 subparagraph (e), the division first must have received approval
431 from the Health Care Financing Administration of the United States
432 Department of Health and Human Services of the change in the state

433 Medicaid plan providing for such reimbursement.

434 (f) The division shall develop and implement a case-mix
435 payment add-on determined by time studies and other valid
436 statistical data which will reimburse a nursing facility for the
437 additional cost of caring for a resident who has a diagnosis of
438 Alzheimer's or other related dementia and exhibits symptoms that
439 require special care. Any such case-mix add-on payment shall be
440 supported by a determination of additional cost. The division
441 shall also develop and implement as part of the fair rental
442 reimbursement system for nursing facility beds, an Alzheimer's
443 resident bed depreciation enhanced reimbursement system which will
444 provide an incentive to encourage nursing facilities to convert or
445 construct beds for residents with Alzheimer's or other related
446 dementia.

447 (g) The Division of Medicaid shall develop and
448 implement a referral process for long-term care alternatives for
449 Medicaid beneficiaries and applicants. No Medicaid beneficiary
450 shall be admitted to a Medicaid-certified nursing facility unless
451 a licensed physician certifies that nursing facility care is
452 appropriate for that person on a standardized form to be prepared
453 and provided to nursing facilities by the Division of Medicaid.
454 The physician shall forward a copy of that certification to the
455 Division of Medicaid within twenty-four (24) hours after it is
456 signed by the physician. Any physician who fails to forward the
457 certification to the Division of Medicaid within the time period
458 specified in this paragraph shall be ineligible for Medicaid
459 reimbursement for any physician's services performed for the
460 applicant. The Division of Medicaid shall determine, through an
461 assessment of the applicant conducted within two (2) business days
462 after receipt of the physician's certification, whether the
463 applicant also could live appropriately and cost-effectively at
464 home or in some other community-based setting if home- or
465 community-based services were available to the applicant. The

466 time limitation prescribed in this paragraph shall be waived in
467 cases of emergency. If the Division of Medicaid determines that a
468 home- or other community-based setting is appropriate and
469 cost-effective, the division shall:
470 (i) Advise the applicant or the applicant's legal
471 representative that a home- or other community-based setting is
472 appropriate;
473 (ii) Provide a proposed care plan and inform the
474 applicant or the applicant's legal representative regarding the
475 degree to which the services in the care plan are available in a
476 home- or in other community-based setting rather than nursing
477 facility care; and
478 (iii) Explain that such plan and services are
479 available only if the applicant or the applicant's legal
480 representative chooses a home- or community-based alternative to
481 nursing facility care, and that the applicant is free to choose
482 nursing facility care.
483 The Division of Medicaid may provide the services described
484 in this paragraph (g) directly or through contract with case
485 managers from the local Area Agencies on Aging, and shall
486 coordinate long-term care alternatives to avoid duplication with
487 hospital discharge planning procedures.
488 Placement in a nursing facility may not be denied by the
489 division if home- or community-based services that would be more
490 appropriate than nursing facility care are not actually available,
491 or if the applicant chooses not to receive the appropriate home-
492 or community-based services.
493 The division shall provide an opportunity for a fair hearing
494 under federal regulations to any applicant who is not given the
495 choice of home- or community-based services as an alternative to
496 institutional care.
497 The division shall make full payment for long-term care
498 alternative services.

499 The division shall apply for necessary federal waivers to
500 assure that additional services providing alternatives to nursing
501 facility care are made available to applicants for nursing
502 facility care.
503 (5) Periodic screening and diagnostic services for
504 individuals under age twenty-one (21) years as are needed to
505 identify physical and mental defects and to provide health care
506 treatment and other measures designed to correct or ameliorate
507 defects and physical and mental illness and conditions discovered
508 by the screening services regardless of whether these services are
509 included in the state plan. The division may include in its
510 periodic screening and diagnostic program those discretionary
511 services authorized under the federal regulations adopted to
512 implement Title XIX of the federal Social Security Act, as
513 amended. The division, in obtaining physical therapy services,
514 occupational therapy services, and services for individuals with
515 speech, hearing and language disorders, may enter into a
516 cooperative agreement with the State Department of Education for
517 the provision of such services to handicapped students by public
518 school districts using state funds which are provided from the
519 appropriation to the Department of Education to obtain federal
520 matching funds through the division. The division, in obtaining
521 medical and psychological evaluations for children in the custody
522 of the State Department of Human Services may enter into a
523 cooperative agreement with the State Department of Human Services
524 for the provision of such services using state funds which are
525 provided from the appropriation to the Department of Human
526 Services to obtain federal matching funds through the division.
527 On July 1, 1993, all fees for periodic screening and
528 diagnostic services under this paragraph (5) shall be increased by
529 twenty-five percent (25%) of the reimbursement rate in effect on
530 June 30, 1993.
531 (6) Physician's services. All fees for physicians' services

532 that are covered only by Medicaid shall be reimbursed at ninety
533 percent (90%) of the rate established on January 1, 1999, and as
534 adjusted each January thereafter, under Medicare (Title XVIII of
535 the Social Security Act), as amended, and which shall in no event
536 be less than seventy percent (70%) of the rate established on
537 January 1, 1994. All fees for physicians' services that are
538 covered by both Medicare and Medicaid shall be reimbursed at ten
539 percent (10%) of the adjusted Medicare payment established on
540 January 1, 1999, and as adjusted each January thereafter, under
541 Medicare (Title XVIII of the Social Security Act), as amended, and
542 which shall in no event be less than seven percent (7%) of the
543 adjusted Medicare payment established on January 1, 1994.
544 (7) (a) Home health services for eligible persons, not to
545 exceed in cost the prevailing cost of nursing facility services,
546 not to exceed sixty (60) visits per year.
547 (b) Repealed.
548 (8) Emergency medical transportation services. On January
549 1, 1994, emergency medical transportation services shall be
550 reimbursed at seventy percent (70%) of the rate established under
551 Medicare (Title XVIII of the Social Security Act), as amended.
552 "Emergency medical transportation services" shall mean, but shall
553 not be limited to, the following services by a properly permitted
554 ambulance operated by a properly licensed provider in accordance
555 with the Emergency Medical Services Act of 1974 (Section 41-59-1
556 et seq.): (i) basic life support, (ii) advanced life support,
557 (iii) mileage, (iv) oxygen, (v) intravenous fluids, (vi)
558 disposable supplies, (vii) similar services.
559 (9) Legend and other drugs as may be determined by the
560 division. The division may implement a program of prior approval
561 for drugs to the extent permitted by law. Payment by the division
562 for covered multiple source drugs shall be limited to the lower of
563 the upper limits established and published by the Health Care
564 Financing Administration (HCFA) plus a dispensing fee of Four

565 Dollars and Ninety-one Cents ($4.91), or the estimated acquisition
566 cost (EAC) as determined by the division plus a dispensing fee of
567 Four Dollars and Ninety-one Cents ($4.91), or the providers' usual
568 and customary charge to the general public. The division shall
569 allow five (5) prescriptions per month for noninstitutionalized
570 Medicaid recipients; however, exceptions for up to ten (10)
571 prescriptions per month shall be allowed, with the approval of the
572 director, and there shall be no limit on the number of
573 prescriptions per month for noninstitutionalized Medicaid
574 recipients who are eligible under Section 43-13-115(20).
575 Prescriptions for noninstitutionalized Medicaid recipients who are
576 eligible under Section 43-13-115(20) shall be funded from state
577 funds appropriated to the Division of Medicaid from the Health
578 Care Expendable Fund established under Section 43-13-407 and
579 matching federal funds.
580 Payment for other covered drugs, other than multiple source
581 drugs with HCFA upper limits, shall not exceed the lower of the
582 estimated acquisition cost as determined by the division plus a
583 dispensing fee of Four Dollars and Ninety-one Cents ($4.91) or the
584 providers' usual and customary charge to the general public.
585 Payment for nonlegend or over-the-counter drugs covered on
586 the division's formulary shall be reimbursed at the lower of the
587 division's estimated shelf price or the providers' usual and
588 customary charge to the general public. No dispensing fee shall
589 be paid.
590 The division shall develop and implement a program of payment
591 for additional pharmacist services, with payment to be based on
592 demonstrated savings, but in no case shall the total payment
593 exceed twice the amount of the dispensing fee.
594 As used in this paragraph (9), "estimated acquisition cost"
595 means the division's best estimate of what price providers
596 generally are paying for a drug in the package size that providers
597 buy most frequently. Product selection shall be made in

598 compliance with existing state law; however, the division may
599 reimburse as if the prescription had been filled under the generic
600 name. The division may provide otherwise in the case of specified
601 drugs when the consensus of competent medical advice is that
602 trademarked drugs are substantially more effective.

603 (10) Dental care that is an adjunct to treatment of an acute
604 medical or surgical condition; services of oral surgeons and
605 dentists in connection with surgery related to the jaw or any
606 structure contiguous to the jaw or the reduction of any fracture
607 of the jaw or any facial bone; and emergency dental extractions
608 and treatment related thereto. On July 1, 1999, all fees for
609 dental care and surgery under authority of this paragraph (10)
610 shall be increased to one hundred sixty percent (160%) of the
611 amount of the reimbursement rate that was in effect on June 30,
612 1999. It is the intent of the Legislature to encourage more
613 dentists to participate in the Medicaid program.

614 (11) Eyeglasses necessitated by reason of eye surgery, and
615 as prescribed by a physician skilled in diseases of the eye or an
616 optometrist, whichever the patient may select.

617 (12) Intermediate care facility services.

618 (a) The division shall make full payment to all
619 intermediate care facilities for the mentally retarded for each
620 day, not exceeding eighty-four (84) days per year, that a patient
621 is absent from the facility on home leave. Payment may be made
622 for the following home leave days in addition to the 84-day
623 limitation: Christmas, the day before Christmas, the day after
624 Christmas, Thanksgiving, the day before Thanksgiving and the day
625 after Thanksgiving. However, before payment may be made for more
626 than eighteen (18) home leave days in a year for a patient, the
627 patient must have written authorization from a physician stating
628 that the patient is physically and mentally able to be away from
629 the facility on home leave. Such authorization must be filed with
630 the division before it will be effective, and the authorization

631 shall be effective for three (3) months from the date it is
632 received by the division, unless it is revoked earlier by the
633 physician because of a change in the condition of the patient.
634 (b) All state-owned intermediate care facilities for
635 the mentally retarded shall be reimbursed on a full reasonable
636 cost basis.
637 (13) Family planning services, including drugs, supplies and
638 devices, when such services are under the supervision of a
639 physician.
640 (14) Clinic services. Such diagnostic, preventive,
641 therapeutic, rehabilitative or palliative services furnished to an
642 outpatient by or under the supervision of a physician or dentist
643 in a facility which is not a part of a hospital but which is
644 organized and operated to provide medical care to outpatients.
645 Clinic services shall include any services reimbursed as
646 outpatient hospital services which may be rendered in such a
647 facility, including those that become so after July 1, 1991. On
648 July 1, 1999, all fees for physicians' services reimbursed under
649 authority of this paragraph (14) shall be reimbursed at ninety
650 percent (90%) of the rate established on January 1, 1999, and as
651 adjusted each January thereafter, under Medicare (Title XVIII of
652 the Social Security Act), as amended, and which shall in no event
653 be less than seventy percent (70%) of the rate established on
654 January 1, 1994. All fees for physicians' services that are
655 covered by both Medicare and Medicaid shall be reimbursed at ten
656 percent (10%) of the adjusted Medicare payment established on
657 January 1, 1999, and as adjusted each January thereafter, under
658 Medicare (Title XVIII of the Social Security Act), as amended, and
659 which shall in no event be less than seven percent (7%) of the
660 adjusted Medicare payment established on January 1, 1994. On July
661 1, 1999, all fees for dentists' services reimbursed under
662 authority of this paragraph (14) shall be increased to one hundred
663 sixty percent (160%) of the amount of the reimbursement rate that

664 was in effect on June 30, 1999.

665 (15) Home- and community-based services, as provided under
666 Title XIX of the federal Social Security Act, as amended, under
667 waivers, subject to the availability of funds specifically
668 appropriated therefor by the Legislature. Payment for such
669 services shall be limited to individuals who would be eligible for
670 and would otherwise require the level of care provided in a
671 nursing facility. The home- and community-based services
672 authorized under this paragraph shall be expanded over a five-year
673 period beginning July 1, 1999. The division shall certify case
674 management agencies to provide case management services and
675 provide for home- and community-based services for eligible
676 individuals under this paragraph. The home- and community-based
677 services under this paragraph and the activities performed by
678 certified case management agencies under this paragraph shall be
679 funded using state funds that are provided from the appropriation
680 to the Division of Medicaid and used to match federal funds.

681 (16) Mental health services. Approved therapeutic and case
682 management services provided by (a) an approved regional mental
683 health/retardation center established under Sections 41-19-31
684 through 41-19-39, or by another community mental health service
685 provider meeting the requirements of the Department of Mental
686 Health to be an approved mental health/retardation center if
687 determined necessary by the Department of Mental Health, using
688 state funds which are provided from the appropriation to the State
689 Department of Mental Health and used to match federal funds under
690 a cooperative agreement between the division and the department,
691 or (b) a facility which is certified by the State Department of
692 Mental Health to provide therapeutic and case management services,
693 to be reimbursed on a fee for service basis. Any such services
694 provided by a facility described in paragraph (b) must have the
695 prior approval of the division to be reimbursable under this
696 section. After June 30, 1997, mental health services provided by

697 regional mental health/retardation centers established under
698 Sections 41-19-31 through 41-19-39, or by hospitals as defined in
699 Section 41-9-3(a) and/or their subsidiaries and divisions, or by
700 psychiatric residential treatment facilities as defined in Section
701 43-11-1, or by another community mental health service provider
702 meeting the requirements of the Department of Mental Health to be
703 an approved mental health/retardation center if determined
704 necessary by the Department of Mental Health, shall not be
705 included in or provided under any capitated managed care pilot
706 program provided for under paragraph (24) of this section.
707 (17) Durable medical equipment services and medical supplies
708 restricted to patients receiving home health services unless
709 waived on an individual basis by the division. The division shall
710 not expend more than Three Hundred Thousand Dollars ($300,000.00)
711 of state funds annually to pay for medical supplies authorized
712 under this paragraph.
713 (18) Notwithstanding any other provision of this section to
714 the contrary, the division shall make additional reimbursement to
715 hospitals which serve a disproportionate share of low-income
716 patients and which meet the federal requirements for such payments
717 as provided in Section 1923 of the federal Social Security Act and
718 any applicable regulations.
719 (19) (a) Perinatal risk management services. The division
720 shall promulgate regulations to be effective from and after
721 October 1, 1988, to establish a comprehensive perinatal system for
722 risk assessment of all pregnant and infant Medicaid recipients and
723 for management, education and follow-up for those who are
724 determined to be at risk. Services to be performed include case
725 management, nutrition assessment/counseling, psychosocial
726 assessment/counseling and health education. The division shall
727 set reimbursement rates for providers in conjunction with the
728 State Department of Health.
729 (b) Early intervention system services. The division

730 shall cooperate with the State Department of Health, acting as
731 lead agency, in the development and implementation of a statewide
732 system of delivery of early intervention services, pursuant to
733 Part H of the Individuals with Disabilities Education Act (IDEA).
734 The State Department of Health shall certify annually in writing
735 to the director of the division the dollar amount of state early
736 intervention funds available which shall be utilized as a
737 certified match for Medicaid matching funds. Those funds then
738 shall be used to provide expanded targeted case management
739 services for Medicaid eligible children with special needs who are
740 eligible for the state's early intervention system.
741 Qualifications for persons providing service coordination shall be
742 determined by the State Department of Health and the Division of
743 Medicaid.
744 (20) Home- and community-based services for physically
745 disabled approved services as allowed by a waiver from the U.S.
746 Department of Health and Human Services for home- and
747 community-based services for physically disabled people using
748 state funds which are provided from the appropriation to the State
749 Department of Rehabilitation Services and used to match federal
750 funds under a cooperative agreement between the division and the
751 department, provided that funds for these services are
752 specifically appropriated to the Department of Rehabilitation
753 Services.
754 (21) Nurse practitioner services. Services furnished by a
755 registered nurse who is licensed and certified by the Mississippi
756 Board of Nursing as a nurse practitioner including, but not
757 limited to, nurse anesthetists, nurse midwives, family nurse
758 practitioners, family planning nurse practitioners, pediatric
759 nurse practitioners, obstetrics-gynecology nurse practitioners and
760 neonatal nurse practitioners, under regulations adopted by the
761 division. Reimbursement for such services shall not exceed ninety
762 percent (90%) of the reimbursement rate for comparable services

763 rendered by a physician.

764 (22) Ambulatory services delivered in federally qualified
765 health centers and in clinics of the local health departments of
766 the State Department of Health for individuals eligible for
767 medical assistance under this article based on reasonable costs as
768 determined by the division.

769 (23) Inpatient psychiatric services. Inpatient psychiatric
770 services to be determined by the division for recipients under age
771 twenty-one (21) which are provided under the direction of a
772 physician in an inpatient program in a licensed acute care
773 psychiatric facility or in a licensed psychiatric residential
774 treatment facility, before the recipient reaches age twenty-one
775 (21) or, if the recipient was receiving the services immediately
776 before he reached age twenty-one (21), before the earlier of the
777 date he no longer requires the services or the date he reaches age
778 twenty-two (22), as provided by federal regulations. Recipients
779 shall be allowed forty-five (45) days per year of psychiatric
780 services provided in acute care psychiatric facilities, and shall
781 be allowed unlimited days of psychiatric services provided in
782 licensed psychiatric residential treatment facilities.

783 (24) Managed care services in a program to be developed by
784 the division by a public or private provider. Notwithstanding any
785 other provision in this article to the contrary, the division
786 shall establish rates of reimbursement to providers rendering care
787 and services authorized under this section, and may revise such
788 rates of reimbursement without amendment to this section by the
789 Legislature for the purpose of achieving effective and accessible
790 health services, and for responsible containment of costs. This
791 shall include, but not be limited to, one (1) module of capitated
792 managed care in a rural area, and one (1) module of capitated
793 managed care in an urban area.

794 (25) Birthing center services.

795 (26) Hospice care. As used in this paragraph, the term

796 "hospice care" means a coordinated program of active professional
797 medical attention within the home and outpatient and inpatient
798 care which treats the terminally ill patient and family as a unit,
799 employing a medically directed interdisciplinary team. The
800 program provides relief of severe pain or other physical symptoms
801 and supportive care to meet the special needs arising out of
802 physical, psychological, spiritual, social and economic stresses
803 which are experienced during the final stages of illness and
804 during dying and bereavement and meets the Medicare requirements
805 for participation as a hospice as provided in 42 CFR Part 418.
806 (27) Group health plan premiums and cost sharing if it is
807 cost effective as defined by the Secretary of Health and Human
808 Services.
809 (28) Other health insurance premiums which are cost
810 effective as defined by the Secretary of Health and Human
811 Services. Medicare eligible must have Medicare Part B before
812 other insurance premiums can be paid.
813 (29) The Division of Medicaid may apply for a waiver from
814 the Department of Health and Human Services for home- and
815 community-based services for developmentally disabled people using
816 state funds which are provided from the appropriation to the State
817 Department of Mental Health and used to match federal funds under
818 a cooperative agreement between the division and the department,
819 provided that funds for these services are specifically
820 appropriated to the Department of Mental Health.
821 (30) Pediatric skilled nursing services for eligible persons
822 under twenty-one (21) years of age.
823 (31) Targeted case management services for children with
824 special needs, under waivers from the U.S. Department of Health
825 and Human Services, using state funds that are provided from the
826 appropriation to the Mississippi Department of Human Services and
827 used to match federal funds under a cooperative agreement between
828 the division and the department.

829 (32) Care and services provided in Christian Science
830 Sanatoria operated by or listed and certified by The First Church
831 of Christ Scientist, Boston, Massachusetts, rendered in connection
832 with treatment by prayer or spiritual means to the extent that
833 such services are subject to reimbursement under Section 1903 of
834 the Social Security Act.
835 (33) Podiatrist services.
836 (34) Personal care services provided in a pilot program to
837 not more than forty (40) residents at a location or locations to
838 be determined by the division and delivered by individuals
839 qualified to provide such services, as allowed by waivers under
840 Title XIX of the Social Security Act, as amended. The division
841 shall not expend more than Three Hundred Thousand Dollars
842 ($300,000.00) annually to provide such personal care services.
843 The division shall develop recommendations for the effective
844 regulation of any facilities that would provide personal care
845 services which may become eligible for Medicaid reimbursement
846 under this section, and shall present such recommendations with
847 any proposed legislation to the 1996 Regular Session of the
848 Legislature on or before January 1, 1996.
849 (35) Services and activities authorized in Sections
850 43-27-101 and 43-27-103, using state funds that are provided from
851 the appropriation to the State Department of Human Services and
852 used to match federal funds under a cooperative agreement between
853 the division and the department.
854 (36) Nonemergency transportation services for
855 Medicaid-eligible persons, to be provided by the Department of
856 Human Services. The division may contract with additional
857 entities to administer nonemergency transportation services as it
858 deems necessary. All providers shall have a valid driver's
859 license, vehicle inspection sticker and a standard liability
860 insurance policy covering the vehicle.
861 (37) Targeted case management services for individuals with

862 chronic diseases, with expanded eligibility to cover services to
863 uninsured recipients, on a pilot program basis. This paragraph
864 (37) shall be contingent upon continued receipt of special funds
865 from the Health Care Financing Authority and private foundations
866 who have granted funds for planning these services. No funding
867 for these services shall be provided from State General Funds.
868 (38) Chiropractic services: a chiropractor's manual
869 manipulation of the spine to correct a subluxation, if x-ray
870 demonstrates that a subluxation exists and if the subluxation has
871 resulted in a neuromusculoskeletal condition for which
872 manipulation is appropriate treatment. Reimbursement for
873 chiropractic services shall not exceed Seven Hundred Dollars
874 ($700.00) per year per recipient.
875 Notwithstanding any provision of this article, except as
876 authorized in the following paragraph and in Section 43-13-139,
877 neither (a) the limitations on quantity or frequency of use of or
878 the fees or charges for any of the care or services available to
879 recipients under this section, nor (b) the payments or rates of
880 reimbursement to providers rendering care or services authorized
881 under this section to recipients, may be increased, decreased or
882 otherwise changed from the levels in effect on July 1, 1986,
883 unless such is authorized by an amendment to this section by the
884 Legislature. However, the restriction in this paragraph shall not
885 prevent the division from changing the payments or rates of
886 reimbursement to providers without an amendment to this section
887 whenever such changes are required by federal law or regulation,
888 or whenever such changes are necessary to correct administrative
889 errors or omissions in calculating such payments or rates of
890 reimbursement.
891 Notwithstanding any provision of this article, no new groups
892 or categories of recipients and new types of care and services may
893 be added without enabling legislation from the Mississippi
894 Legislature, except that the division may authorize such changes

895 without enabling legislation when such addition of recipients or
896 services is ordered by a court of proper authority. The director
897 shall keep the Governor advised on a timely basis of the funds
898 available for expenditure and the projected expenditures. In the
899 event current or projected expenditures can be reasonably
900 anticipated to exceed the amounts appropriated for any fiscal
901 year, the Governor, after consultation with the director, shall
902 discontinue any or all of the payment of the types of care and
903 services as provided herein which are deemed to be optional
904 services under Title XIX of the federal Social Security Act, as
905 amended, for any period necessary to not exceed appropriated
906 funds, and when necessary shall institute any other cost
907 containment measures on any program or programs authorized under
908 the article to the extent allowed under the federal law governing
909 such program or programs, it being the intent of the Legislature
910 that expenditures during any fiscal year shall not exceed the
911 amounts appropriated for such fiscal year.
912 SECTION 3. This act shall take effect and be in force from
913 and after July 1, 2000.